STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011253	A. BUILDING: _____ B. WING _____	R 04/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS SENIOR HOME SOLUTIONS INC	156-A SAGAMORE PKWY W WEST LAFAYETTE, IN 47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments This was a revisit for the State re-licensure survey completed on 12/18/13 and 12/19/13. Survey Date: 04/04/14 Facility #: 0011253 Medicaid Vendor #: N/A Surveyor: Shannon Pietraszewski, RN, PHNS All 34 deficiencies were found corrected during this survey. Current Census: 3 Quality Review: Joyce Elder, MSN, BSN, RN April 4, 2014	{N 000}		